GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
ACTING DIRECTOR

February 8, 2024

Karen Laseck
Pathway Home of Elsie, LLC
133 W. Main Street
Elsie, MI 48831

RE: License #: AM190394424
Investigation #: 2024A1033017
Pathway Home Of Elsie

Dear Ms. Laseck:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 284-9730.

Sincerely,

Jana Lipps, Licensing Consultant
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909

enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT
THIS REPORT CONTAINS QUOTED PROFANITY

I. IDENTIFYING INFORMATION

License #:	AM190394424
Investigation #:	2024A1033017
Complaint Receipt Date:	12/12/2023
Investigation Initiation Date:	12/14/2023
Report Due Date:	02/10/2024
Licensee Name:	Pathway Home of Elsie, LLC
Licensee Address:	133 W. Main Street Elsie, MI 48831
Licensee Telephone #:	(517) 281-2729
Administrator:	Karen Laseck, Designee
Licensee Designee:	Karen Laseck, Designee
Name of Facility:	Pathway Home of Elsie
Facility Address:	133 W Main Street Elsie, MI 48831
Facility Telephone #:	(517) 281-2729
Original Issuance Date:	10/31/2018
License Status:	REGULAR
Effective Date:	04/30/2023
Expiration Date:	04/29/2025
Capacity:	11
Program Type:	AGED

II. ALLEGATION(S)

	Violation Established?
Licensee Designee, Karen Laseck, provides direct care to residents while she is intoxicated.	No
Licensee Designee, Karen Laseck, treats residents in a derogatory manner by name calling and swearing at residents.	No
Resident B experienced a fall in the foyer and was left on the floor all night by direct care staff.	Yes
Resident A experienced a fall at the facility and broke her hip due to direct care staff not providing adequate supervision and protection.	No

III. METHODOLOGY

12/12/2023	Special Investigation Intake 2024A1033017
12/14/2023	Contact - Telephone call made- Attempt to interview Complainant. Voicemail message left.
12/14/2023	Special Investigation Initiated – Telephone- Interview with Citizen 1, via telephone.
12/20/2023	Contact - Telephone call made- Interview with the Complainant, via telephone.
12/21/2023	Inspection Completed On-site- Interviews with direct care staff, Shylyn Coon, licensee designee, Karen Laseck, Resident C, & Resident D. Review of resident records initiated.
01/23/2024	Contact - Telephone call made- Attempt to interview direct care staff, Lanette Frost. Voicemail message left, awaiting a response.
01/23/2024	Contact - Telephone call made Interview with direct care staff, Mariyah Langlois, via telephone.
01/23/2024	Contact – Telephone call made Interview with direct care staff, Maelinda Burgess, via telephone.
01/24/2024	Exit Conference- Conducted via telephone with licensee designee, Karen Laseck. Voicemail message left noting findings.

ALLEGATION: Licensee Designee, Karen Laseck, provides direct care to residents while she is intoxicated.

INVESTIGATION:

On 12/13/23 I received an online complaint regarding the Pathway Home of Elsie, adult foster care facility (the facility). The complaint alleged that Licensee Designee, Karen Laseck, provides direct care to residents while she is under the influence of alcohol. On 12/14/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that they formerly provided direct care at the facility. Citizen 1 reported that while working at the facility, Ms. Laseck did come to the facility and provide direct care to residents while she was intoxicated. Citizen 1 reported that they could smell alcohol on Ms. Laseck when she arrived at the facility to provide direct care. Citizen 1 reported that they also observed Ms. Laseck slurring her words. Citizen 1 reported that they have never seen Ms. Laseck drink alcohol while at the facility and have no direct knowledge of when and where the alcohol was consumed.

On 12/20/23 I interviewed the Complainant, via telephone. Complainant reported that they have observed Ms. Laseck arrive at the facility to provide direct care to residents, and she was drunk. Complainant reported that they knew Ms. Laseck was drunk because alcohol could be smelled on Ms. Laseck's person. Complainant reported that they have not witnessed Ms. Laseck consume alcohol at the facility and have no knowledge of when and where Ms. Laseck may have consumed the alcohol. Complainant reported that they have asked Ms. Laseck about whether she had been consuming alcohol prior to providing resident care, about one year ago. Complainant reported that Ms. Laseck denied any allegations that she consumes alcohol prior to providing direct care to residents.

On 12/21/23 I conducted an unannounced, on-site investigation at the facility. I interviewed Ms. Laseck. Ms. Laseck reported that she has never consumed alcohol prior to providing direct care to residents at the facility. At this unannounced investigation I observed Ms. Laseck to be well groomed and to not have any scent of alcohol around her person. She did not appear intoxicated during this investigation and was able to answer all questions in a coherent manner.

On 12/21/23, during on-site investigation, I interviewed Resident C. Resident C reported that she has never experienced any of the direct care staff or Ms. Laseck, providing direct care to the residents while under the influence of alcohol.

On 12/21/23, during on-site investigation, I interviewed Resident D. Resident D reported that she understands what it looks like to present as intoxicated as she reported she was previously a heavy user of alcohol. She reported that her father was also a heavy drinker of alcohol. Resident D stated that she has never observed any of the direct care staff, or Ms. Laseck, providing direct care to residents while under the influence of alcohol.

During on-site investigation on 12/21/23 I interviewed direct care staff, Shylyn Coon. Ms. Coon reported that she has only worked at the facility for a short period of time. Ms. Coon reported that Ms. Laseck usually arrives at the facility every day between the hours of 11am and 1pm. She reported that she has not observed Ms. Laseck to be under the influence of alcohol while providing direct care to residents.

On 1/23/24 I interviewed direct care staff, Mariyah Langlois, via telephone. Ms. Langlois reported that she has observed Ms. Laseck under the influence of alcohol but has never observed Ms. Laseck providing direct care to residents while she is under the influence of alcohol.

On 1/23/24 I interviewed direct care staff, Maelinda Burgess, via telephone. Ms. Burgess reported that she has never witnessed Ms. Laseck under the influence of alcohol while providing direct care to residents at the facility.

APPLICABLE RULE	
R 400.14201	**Qualifications of administrator, direct care staff, licensee, and members of household; provision of names of employee, volunteer, or member of household on parole or probation or convicted of felony; food service staff.**
	(9) A licensee and the administrator shall possess all of the following qualifications: **(b) Be capable of appropriately handling emergency situations.**
ANALYSIS:	Based upon interviews with Citizen 1, Complainant, Ms. Laseck, Ms. Coon, Resident C, Resident D, Ms. Burgess and Ms. Langlois, it can be determined that there is not adequate evidence licensee designee Ms. Laseck has provided direct care to residents of the facility, while she is under the influence of alcohol. Ms. Laseck denied these allegations and there are no eyewitness accounts of Ms. Laseck drinking alcohol while providing direct care.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Licensee Designee, Karen Laseck, treats residents in a derogatory manner by name calling and swearing at residents.

INVESTIGATION:

On 12/13/23 I received an online complaint regarding the facility. The complaint alleged that Ms. Laseck treats the residents in a derogatory manner by name calling and swearing at the residents. On 12/14/23 I interviewed Citizen 1, via telephone. Citizen 1 reported that she has never observed Ms. Laseck treat the residents of the facility in a derogatory manner.

On 12/20/23 I interviewed the Complainant, via telephone. Complainant reported that they have observed Ms. Laseck mock Resident D for using breathing techniques to control her anxiety. Complainant reported that Ms. Laseck has expressed that Resident D was “breathing too hard” and then mimicked this breathing to Complainant. Complainant also reported that Ms. Laseck has stated, “I’m not going to put up with your shit!”, when interacting with residents. Complainant could not recall the specific resident these statements were directed toward.

During on-site investigation on 12/21/23 I interviewed Ms. Laseck. Ms. Laseck denied that she speaks with the residents in a derogatory manner.

During on-site investigation on 12/21/23 I interviewed Resident C. Resident C reported that she has never heard any of the direct care staff, including Ms. Laseck, speak to the residents in a derogatory manner.

During on-site investigation on 12/21/23 I interviewed Resident D. Resident D reported “I love it here!” when talking about the facility. Resident D reported that Ms. Laseck has “scolded” her for “holding her breath”. She reported that she holds her breath when she gets angry. She further reported that Ms. Laseck will correct her and tell her not to do this. Resident D reported that she has not observed any of the direct care staff, including Ms. Laseck, speak to the residents in a derogatory manner.

During on-site investigation on 12/21/23 I interviewed Ms. Coon. Ms. Coon reported that she has never observed any direct care staff, including Ms. Laseck, speak with residents in a derogatory manner.

On 1/23/24 I interviewed Ms. Langlois, via telephone. Ms. Langlois reported that she has never observed Ms. Laseck to speak with the residents in a derogatory manner.

On 1/23/24 I interviewed Ms. Burgess, via telephone. Ms. Burgess reported that she has never observed Ms. Laseck speaking with the residents in a derogatory manner.

APPLICABLE RULE	
R 400.14304	**Resident rights; licensee responsibilities.**
	(1) Upon a resident's admission to the home, a licensee shall inform a resident or the resident's designated representative of, explain to the resident or the resident's designated representative, and provide to the resident or the resident's designated representative, a copy of all of the following resident rights:

	(o) The right to be treated with consideration and respect, with due recognition of personal dignity, individuality, and the need for privacy. **(2) A licensee shall respect and safeguard the resident's rights specified in subrule (1) of this rule.**
ANALYSIS:	Based upon interviews with Citizen 1, Complainant, Ms. Laseck, Ms. Coon, Resident C, Resident D, Ms. Langlois, and Ms. Burgess it can be determined that there is not sufficient evidence to suggest that Ms. Laseck is speaking with the residents in a derogatory manner.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION: Resident B experienced a fall in the foyer and was left on the floor all night by direct care staff.

INVESTIGATION:

On 12/20/23 I received additional, verbal allegations, that Resident B experienced a fall in the foyer of the facility and was left on the floor all night by the direct care staff on duty at the time. On 12/20/23 I interviewed Complainant, via telephone. Complainant reported that it was reported to them that early this week direct care staff, Lanette Frost, had been working the midnight shift at the facility and Resident B experienced a fall in the foyer. Complainant reported Ms. Frost reported this information to Complainant. Complainant reported that Ms. Frost indicated that she made telephone contact to Ms. Laseck regarding Resident B falling and being on the floor in the foyer and was told by Ms. Laseck to put a pillow under her head and blankets on her and leave Resident B on the floor in the foyer until the morning shift arrived to assist Ms. Frost in lifting Resident B off from the floor. Complainant reported that to their knowledge Ms. Frost did comply with Ms. Laseck's orders to leave Resident B on the floor all night and Resident B was still on the floor in the foyer the next morning when Ms. Langlois arrived for her shift.

During on-site investigation on 12/21/23 I interviewed Ms. Laseck regarding the allegations. Ms. Laseck reported that on 12/13/23 around 10pm, Resident B did experience weakness while walking to her resident bedroom and Ms. Frost lowered Resident B to the floor in the foyer. Ms. Laseck reported Resident B did not fall, but that Ms. Frost lowered her to the floor. Ms. Laseck reported Ms. Frost called her on the telephone to discuss what to do as she could not get Resident B off the floor on her own as Resident B was too weak for a one person assist. Ms. Laseck reported she advised Ms. Frost to maintain comfort for Resident B, as Resident B did not appear to be in any immediate distress and was not visibly injured. Ms. Laseck reported that she advised Ms. Frost to get the mattress off Resident B's bed and place it on the ground and then roll Resident B onto the mattress for comfort. She reported that she advised Ms. Frost to then get Resident B's bedding and make

Resident B comfortable on the mattress, on the floor in the foyer, for the evening and wait for the morning direct care staff workers to arrive to assist with getting Resident B up off the floor. Ms. Laseck reported that she did not offer to come to the facility to assist Ms. Frost as she knew that she and Ms. Frost would not be able to get Resident B up off the ground on their own. Ms. Laseck reported that she advised Ms. Frost not to call 911 for assistance as Resident B did not appear to be in distress and this did not appear to be an emergency. Ms. Laseck reported that when Ms. Langlois arrived for her shift at 6am the following morning she found that Resident B appeared to have tremors and Ms. Langlois made the decision to call 911 for assistance. Ms. Laseck reported that Resident B was taken to the hospital and was found to have a urinary tract infection which had caused her sudden onset of weakness. Ms. Laseck reported that she had advised Ms. Frost to follow Resident B's vitals throughout the evening and call with any changes. She reported that Ms. Frost did not call her back throughout the evening and that Ms. Laseck also did not contact Ms. Frost for follow up as she assumed things were going okay since she had not heard back from Ms. Frost throughout the evening.

During on-site investigation on 12/21/23 I reviewed the document, *Pathway Home of Elsie Fall/Incident/Accident Report*, for Resident B, dated 12/14/23. The incident report documents that Ms. Laseck was informed of Resident B being on the floor at 9:55pm on 12/13/23. The incident report also documented that 911 was called on 12/14/23 at 6am. The following narrative was documented on this report by Ms. Laseck, "Lanette (RCS) contacted this writer. RCS stated that Res was lowered to the floor on the rug in the foyer. She stated she attempted to get Res up off the carpet but couldn't. RCS tried to use a w/c for Res to crawl up but Res did not understand instructions. RCS stated she had placed a pillow under her head and covered her with blankets. This writer suggested that RCS pull Res mattress off her bed and log roll her onto it for comfort. RCS stated "ok". This writer told RCS to make her comfortable in the foyer until am when 2 additional staff would be in to assist her. RCS took her BS; results 251mg/dl. No other call was placed to this writer throughout the night. 12/15/23 0600 Call was rec'd from RCS, Mariyah who stated she assessed the Res and that she needed to go to the ER for evaluation. This writer gave Mariyah instructions on how to send Res out via a 911 call. RCS prepared paperwork for transport."

On 1/23/24 I interviewed Ms. Langlois, via telephone, regarding the allegation. Ms. Langlois reported that she had arrived for her scheduled shift at 6am the morning after Resident B had been lowered to the floor in the foyer by Ms. Frost. Ms. Langlois reported that she could not believe what she found as she entered the foyer and found Resident B laying on the ground, with nothing underneath her body except the rug and she was covered with a blanket and had a pillow under her head. Ms. Langlois reported that all Resident B was wearing was a pajama shirt and an incontinence brief. She further reported that Resident B's body was "moist and cold". Ms. Langlois reported that she asked Ms. Frost what had occurred, and Ms. Frost reported that she had called Ms. Laseck the evening prior and Ms. Laseck directed Ms. Frost to wait until the morning when Ms. Langlois arrived to receive help in

getting Resident B off from the floor. Ms. Langlois reported that she and Ms. Frost were able to get Resident B off the floor and then Ms. Langlois called 911 as she did not feel Resident B was doing well, physically. She reported that Resident B was taken to the hospital emergency department and was found to have a urinary tract infection. Ms. Langlois reported that Ms. Frost stated she had been taking Resident B's vitals throughout the evening, but Ms. Langlois stated there was no documentation to support that this occurred.

APPLICABLE RULE	
R 400.14305	**Resident protection.**
	(3) A resident shall be treated with dignity and his or her personal needs, including protection and safety, shall be attended to at all times in accordance with the provisions of the act.
ANALYSIS:	Based upon interviews with the Complainant, Ms. Laseck, & Ms. Langlois, it can be determined that Resident B became weak while walking to her resident bedroom, Ms. Frost lowered her to the ground, and this is where Resident B remained from 10pm on 12/13/23, until 6am on 12/14/23. Ms. Frost was instructed by Ms. Laseck to keep Resident B comfortable on the ground throughout the evening, instead of contacting emergency medical services to check on Resident B's medical condition and assist with providing for her comfort. Resident B was found in a position, where she was laying on a hard surface throughout the evening with minimal clothing, when a call to paramedics could have resolved the situation for the dignity and comfort of Resident B. Therefore, a violation has been established.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION: Resident A experienced a fall at the facility and broke her hip due to direct care staff not providing adequate supervision and protection.

INVESTIGATION:

On 12/20/23 I received additional verbal allegations that Resident A experienced a fall at the facility and broke her hip. The allegations suggested that Resident A was not being provided with adequate supervision and protection. On 12/20/23 I interviewed Complainant, via telephone. Complainant reported that they had received information from Ms. Frost that Resident A fell at the facility while Ms. Burgess was arriving for her scheduled shift. Complainant reported that they are unsure whether Ms. Burgess witnessed the fall. Complainant reported that this fall resulted in a fractured hip for Resident A.

On 12/21/23 I conducted an unannounced on-site investigation at the facility and interviewed Ms. Laseck. Ms. Laseck reported that Resident A experienced a fall while she was ambulating with her cane in the dining room. She reported that Ms. Langlois and Ms. Burgess were both at the facility at the time of the fall but did not witness the fall as this happened around 2pm during shift change. She reported direct care staff made contact with Resident A's son and with 911 and sent Resident A to the emergency department as she appeared to be injured from the fall. Ms. Laseck reported that Resident A did have a hip fracture and has just returned to the facility on 12/20/23.

During on-site investigation on 12/21/23 I interviewed Resident D. Resident D reported that she did not witness Resident A's fall but did see her on the floor after she fell.

During on-site investigation on 12/21/23 I reviewed the following documents from Resident A's resident record:

- *Pathway Home of Elsie Fall/Incident/Accident Report*, dated 12/17/23. This document indicated that Resident A experienced a fall and 911 was called to assist with ambulance transport as Resident A complained of left leg and sternum pain.
- *Health Care Appraisal*, dated 11/20/23. This document identifies that Resident A uses a cane for ambulation.
- *Hospital History & Physical*, from Memorial Hospital in Owosso, dated 12/17/23. This document identifies that Resident A was diagnosed with a left hip fracture due to a fall.
- *Assessment Plan for AFC Residents*, dated 11/20/23. This document noted the use of a cane for ambulation and stability.

On 1/23/24 I interviewed Ms. Langlois via telephone. Ms. Langlois reported that she had been working the morning shift the day that Resident A fell and fractured her hip. She reported that it was close to 2pm as they were preparing for shift change and Ms. Burgess was arriving at the facility. Ms. Langlois reported that she had been walking toward the kitchen, away from the dining room, when she heard Resident A fall. She reported she did not see the incident but there were residents around and the daughter of one of the residents was present for the event. She reported that this individual indicated that Resident A had tried to get up from the table and Resident A's "cane malfunctioned". Ms. Langlois reported that Resident A usually ambulates independent of others with just the assist of her cane. Ms. Langlois reported that she immediately attended to Resident A and realized she was injured and would require 911 assistance. She reported that Resident A's son and 911 were called to assist.

On 1/23/24 I interviewed Ms. Burgess via telephone. Ms. Burgess reported that the day Resident A fell and fractured her hip she had just been arriving at the facility for her shift when this incident occurred. Ms. Burgess reported that she did not witness the fall but heard the fall as she was entering the facility. She reported that she

found Resident A on the floor by the dining room table. Ms. Burgess reported that several residents were present, as well as Ms. Langlois and the daughter of one of the residents. She reported that Resident A's son, Ms. Laseck, and 911 were all called regarding the incident.

APPLICABLE RULE	
R 400.14303	**Resident care; licensee responsibilities.**
	(2) A licensee shall provide supervision, protection, and personal care as defined in the act and as specified in the resident's written assessment plan.
ANALYSIS:	Based upon interviews with Complainant, Ms. Laseck, Ms. Langlois, & Ms. Burgess, as well as review of Resident A's resident record it can be determined that there is not adequate evidence direct care staff were not providing for Resident A's safety and supervision per her assessment plan. Her assessment plan and health care appraisal both indicated she can ambulate with the use of a cane and does not require assistance from direct care staff with ambulation. When she fell, direct care staff acted immediately and sought support from Ms. Laseck, Resident A's son, and called 911 for emergency assistance. Direct care staff attended to Resident A's needs in an appropriate manner. Therefore, a violation has not been established.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, no change to the current status of the license recommended.

01/24/24

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Jana Lipps Date
Licensing Consultant

Approved By:

02/08/2024

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Dawn N. Timm Date
Area Manager